Memorandum

To: CalPERS Long-Term Care Advisory Committee

From: Richard Krolak, Chief, Office of Health Policy Administration

Date: June 6, 2006

Subject: Long-Term Care Program – 2005 and Earlier Rates

Background:

In 1995, CalPERS launched its Long-Term Care Program (Program) to provide an array of benefit plans for long-term care services for active and retired public employees, their spouses, parents and parents-in-law. In later years, adult siblings of active employees and retirees were added to the eligible population. The CalPERS Board of Administration (Board) determined from the onset that the Program would be voluntary, not-for-profit, and self-funded.

What Is the Key Consideration for the Long-Term Care Program?

The principle objective of the Program is to ensure there will be sufficient funding to pay promised benefits - both current and in the future. This requires annual evaluation to ensure the actuarial assumptions continue to be reflective of the Program's actual experience. The key valuation assumptions wherein the Program's experience may deviate adversely are:

- Lapse rates—voluntary terminations of coverage
- Investment earnings rate—investment returns (2004 was 7.0%, current is 7.79%)
- Claim incidence—reflects the likelihood of going into claim
- Claim continuance, severity—reflects the probability of remaining on claim
- Mortality rates–death rate
- Expenses—administrative costs
- Investment volatility--the volatility of an investment is measured by the standard deviation of its rate of return.

The 2004 valuation, completed by Long Term Care Group, Inc. (LTCG) actuaries, was designed to specifically validate prior year assumptions, in particular focusing on claims experience and resulting costs to the Program. Due to time constraints, the 2004 valuation was not able to include the necessary detailed analysis but did identify potential difficulties and recommended further detailed analysis of the Program's actual claims experience and incorporation of that experience as credibility increased. The 2004 valuation, based on the "break-even" best estimates methodology used in prior valuations, indicated a small surplus ($1.3 million or approximately 0.1% of the present value of future premiums), but emphasized the overall fiscal condition of the program was subject to considerable risk particularly as claims experience related to morbidity and mortality factors were adjusted to better reflect actual Program experience.

At the request of Deloitte and Touche, the Board's consulting auditors, two items were included to adjust the "break-even" assumptions in the 2004 valuation to provide projections for adverse deviations to the Program's assumptions. Specifically, the projection period was extended to 50 years from the 40 years used in prior valuations and morbidity and mortality factors improvement were reduced by 50% to better reflect actual Program experience. The impact of these two additional items influenced the claims experience and reduced the estimated surplus by 9.3% ($210.6 million) and 11.2% ($253.6 million) respectively. With these adjustments, recommended to bring the valuation more in line with appropriate insurance industry standards for such programs, the valuation showed a significant negative position for the program in excess of 20%. However, no mitigation action was recommended because of the desire to complete a more detailed analysis of the changes in actuarial assumptions.

United Health Actuarial Services, Inc was engaged to complete the 2005 valuation and was instructed to review prior valuations and focus on reconciliation of issues related to the claims experience as it continues to impact the long term financial viability of the Program. The 2005 valuation included a baseline valuation that incorporated assumptions based on an investment earnings rate of 7.79% (as reflected in the analysis prepared by Wilshire Consulting when the revised asset allocation was adopted by the Board in March 2005), increased expenses, revised claim costs, and higher premiums rates resulting from the 2003 premium rate increase. Further projections were included that incorporated alternative assumptions to reflect additional adverse deviations to the Program's current assumptions. The results of the baseline scenario showed a deficit of 39.4% or $812.8 million.

The key variables that account for the deterioration of the financial position of the Program compared to the 2004 valuation are:

- The 2005 valuation updated the detailed morbidity study initially completed in 2004 using actual Program experience through 6/30/05.

- The 2005 valuation developed revised ultimate claims costs assumptions by credibility-weighting adjusted actual program claims costs against assumed ultimate claims costs.

- Claims payment distributions were revised to reflect emerging experience and were developed to be consistent with current liability/reserve levels.

- Adjustments in amounts associated with individuals already on claim have been revised.

The cumulative effect of these changes is summarized in the valuation analysis:

"These revisions collectively result in a significant increase in projected future claims for the Program as compared to the 2004 valuation. Please note that if experience continues to emerge in a manner consistent with how experience has emerged to date, valuation results will continue to deteriorate."

The Development of Mitigation Strategies

At the direction of the Board and the Health Benefits Committee, Program management & staff, the Long-Term Care Advisory Committee and the Program's independent actuarial consultant have been meeting on a regular basis to investigate, discuss and determine what information and methods should be employed to address the Program's projected deficit and stabilize the necessary funding going into the future to protect present members' benefit payments and ensure that adequate funds are available for current and future administration of the Program. The following assumptions are used to address and support staff's recommendation:

- CalPERS does not have the ability to subsidize this Program with other business lines or financial reserves as does other long term care insurance carriers.

- The Program began at a point in time where the Long-Term Care insurance marketplace was relatively new and volatile.

- The long term care marketplace has matured with many insurers leaving the market; the ones that remain, or are entering the market, are savvier and more financially stable.

- In recent years, new policy sales for this Program have been low but generally better than in the individual long term care marketplace. New policies have balanced departures with total policies-in-force remaining basically flat. Based upon this, the Program cannot look to expand to cover the projected deficit.

- The CalPERS Board has approved two concepts to change the focus of the Program; 1) build reserves and no longer have a "break-even" Program, 2) do not continue to cross subsidize across products.

- In order for CalPERS to compete on a level field with commercial carriers, it would require a segmentation of the current risk pool through two-party discounts (spousal), prime, average, and sub-average rates and other discounts and incentives linked to more restrictive underwriting.

- An expansion of market penetration (new sales), would require a substantial commitment of additional assets including a real sales force (an agent network) as opposed to the marketing currently undertaken by the Program.

Staff Recommendation

Based on the history of the Program and the facts uncovered through in-depth research and discussion, staff and Karl Volkmar, Actuarial Consultant, United Health Actuarial Services, Inc. recommend that the Program focus on ensuring there are adequate reserves to meet the demands of current in-force policies. Staff and Consultant proposes a premium rate increase (Attachment 1) for all 2005 and prior policies which would be self sufficient within each individual product cell to support the development of a comprehensive mitigation plan. The proposed rate increase is based upon the 2006 rates or 20% increase whichever is less, with the exception of "lifetime" policies which will be increased to an appropriate pricing level. This increase is to be adequate enough to build reserves with no cross subsidization for either plan design or age group. This proposal builds reserves without placing an unfair cost burden or disincentives for younger or newer policy holders. With this rate increase, members will be allowed a one-time opportunity to choose between two options as an alternative to the rate increase.

1) The member can step back to a lower Daily Benefit Allowance (DBA), (with a waiver of the underwriting requirements and utilization of their age at issuance into the Program).

2) The member can step back from the “lifetime” policy to a six-year (or shorter) term policy (with a waiver of the underwriting requirements and utilization of their age at issuance into the Program).

Claims experience for this program and broader industry information indicate that for most members a lifetime policy represents an unnecessary cost and over-insurance. Overall, the implementation of this rate increase will bring in-force premium rates in-line with 2006 rate levels.

Staff further recommends that this premium increase become effective on February 1, 2007 or the next available billing date for those members that are not billed on a monthly basis.

A first reading of the proposed mitigation plan will be presented to the Health Benefits Committee on June 20, 2006. It is anticipated that a final decision will be made by the full Board at the August meeting.

Attachment 1: Proposed Long-Term Care Increase for 2005 and Earlier Rates

Attachment 2: Mitigation Analysis Letter

cc: CalPERS Board of Administration